

STRENGTHENING THE FOUNDATION:

A Human Resources for Health Action Plan to Support Universal Health Coverage in the Americas

Chapter II



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INTRODUCTION

Background

The Unit of Human Resources for Health at PAHO is leading an initiative to develop a regional agenda for action in matters of human resources for health post-2015. The new Human Resources for Health (HRH) regional agenda will contribute to and address the major challenges related to evolving population health needs, the renewal of primary health care (PHC) and the objective of universal health coverage in the region of the Americas.

The development of the new HRH agenda will build on the experience of the current decade of HRH launched in Toronto, Canada, in 2005 with its Call for Action, structured along five critical challenges confronting the Region. It will consider the progress made in achieving the Regional Goals for HRH 2007-2015 and the evaluation of national capacities in designing and implementing priority programs in HRH.

It is anticipated that the new agenda will focus primarily on the policy options to deal effectively with the critical HRH obstacles to universal health coverage through the strengthening of a PHC-based health system. A consultative process will be developed to involve the Member States of the Organization in the formation of the regional agenda in 2014. The agenda will align with PAHO's Strategic Plan in HRH, 2014-17, and with the priorities and directions adopted by PAHO's Directing Council in September, 2013 (technical document CD52/6).

Objectives

The primary objectives are to produce a working paper are to:

- i) Explore and organize the critical elements of a national HRH plan aimed at achieving universal health coverage through the development of a PHC-based system;
- ii) Discuss the main policy options to address the elements of the plan as well as the existing evidence supporting them;
- iii) Identify strategies on how to achieve and manage the desired changes in different national environments and health system settings, with illustrative case-studies;
- iv) Review countries with different socio-economic development levels that have achieved UHC to identify their key HRH reforms and strategies; and,
- v) Address conditions for sustainability of HRH policies, anticipating emerging pressures and policy debates.

The report will provide a broad overview of the work completed and highlight some of the successes that have been achieved to date. It will also identify HRH priority areas that require continued support and attention and make recommendations on actions and strategies to support the continued implementation of universal health coverage.

Planning Context

Many of the world's 1.3 billion people with very low incomes do not have access to affordable health care. Out-of-pocket payments create financial barriers that prevent millions of people each year from seeking and receiving needed health services. However, people everywhere - at all income levels - seek protection from the financial risks associated with ill health.

In 2005, the Member States of the WHO adopted a resolution encouraging countries to develop health financing systems aimed at providing universal coverage. This was defined as securing access for all to appropriate health promotion, preventive, curative and rehabilitative services at an affordable cost. It is recognized that it may take many years to achieve universal coverage and full access to a full range of health care services.

With an aging population and a growing burden of non-communicable disease, the Regional workforce aims to shift its emphasis towards a more holistic approach to address chronic conditions and long-term care with a stronger emphasis on health promotion and disease prevention in support of universal health coverage. The needs of the population call for a patient-centered care approach and improved long-term, client-provider relationships. In addition, with gaps in the numbers of human resources available, these needs necessitate strong HRH management skills to retain skilled workers, to maximize productivity and to ensure that working conditions enhance workforce stability and promote access to quality care.

Health is a labour intensive industry and human resources for health cross-cut every aspect of the health care delivery system. Human resources for health are often cited as a major impediment to health system reform. Thus, any significant change in the health care delivery system, if it is to be effective and efficient, also requires a change in the health workforce to support it. Having the right supply, distribution and appropriately deployed health workforce is critical to achieving and maintaining an effective and efficient health care delivery system. Policies on recruitment and retention, education and training, licensure, safety and deployment all impact on the availability, stability and efficiency of the health workforce. The outcomes of the health care delivery systems depend to a large extent on having a workforce that is appropriately trained, deployed, supported and accountable.

As such, a number of *key health policy, planning and partnership issues* will need to be addressed at international, regional and individual country levels, in order to both enhance overall health systems design and management and to strengthen the capacity and stability of the health workforce to support it, if universal health coverage is to be successfully implemented and sustainable over the long term.

Health System Challenges

In many countries throughout the Region of the Americas, a number of traditional system-wide and fiscal, technical and administrative challenges have impeded successful reform in the way HRH are planned and managed. The challenges described below will have to be managed carefully in the future if an optimal health workforce is to be achieved and PHC delivery targets are to be met in a way that is comprehensive, integrated, equitable, effective and sustainable in support of Regional universal health coverage.

i) Economic Development

Health is a resource driven industry and UHC cannot be fully achieved without a stable and viable economy. Economic decline – or even slow economic growth – plus high unemployment and an unstable workforce, lower the tax base upon which UHC is dependent and undermine the capacity and sustainability of the program. As a result of inflation, program expansion and the increasing demands of an aging population, the rise in health care costs can easily outstrip the capacity of governments to respond to them. *Capacity-based planning*, because it is inherently resource sensitive, may be useful in developing implementation strategies that are practical and manageable in the shorter term. This approach could be merged with needs-

based planning goals and targets over the longer term as resources become available, planning capacity is further developed and public and political support is strengthened.

ii) **Identification of Health Care Needs**

Health care needs (population health conditions that will benefit from the provision of care), health care demand (services that are asked for) and health care utilization (services that are actually provided), tend to be used synonymously, but mean very different things. Any definitions of “need” include social, economic and political considerations and are not simply a technical construct based solely on population health profiles. This is not a question to be resolved by health researchers and planners but must be part of an informed, government-lead public debate. The dialogue is necessary to obtain public input and support with respect to the future directions of the health care delivery system, including its scope, implementation and funding.

iii) **Balancing Sector Interests**

There are many stakeholders and partners within the health care delivery system with a range of interests and responsibilities that are not always consonant with health services and funding goals of government. The mandate of health professional associations and unions, for example, is to protect and further the interests of their membership, and as such, not always consonant with the health services and funding goals of governments. Similarly, the private sector has responsibilities with respect to achieving profits, NGO’s may have more short-term, specific program performance targets, and community groups are expected to promote local area interests.

As such, it is important that Ministries of Health take the lead in HRH planning (consistent with government’s long-term fiscal and strategic plans), in establishing goals, targets and accountability measures, while ensuring that key partners and stakeholders have the opportunities to have collaborative input into policy design and direct participation in program implementation. New union negotiation mechanisms and strategies need to be developed that are mutually supportive and better balance short-term sector interests with common, system-wide, long-term goals. New health care models need to be developed with clearly delineated public-private responsibilities that support efficient and sustainable health delivery. New management support systems and performance incentives also need to be established that balance long-term system stability and sustainability, with fair and equitable workforce incentives and payment strategies.

iv) **Population Growth and Migration**

Population growth, supported by positive net increases through in-migration, are required to keep a workforce strong. Retaining trained and experienced workers and attracting qualified external talent keeps local industry competitive and stimulates economic development. The high out-migration of qualified workers lowers the revenue collected by governments to support health and social programs while concurrently increasing the proportion of the population (young and old) who require more of these services but do not contribute to the tax base. Reducing out-migration and building a strong and stable workforce is a key component of most long-term health, social and economic policy strategies that must include employment creation, improved working conditions, competitive salaries, incentives and benefits, educational and career opportunities, and worker health and safety.

As shortages for HRH increase, the international competition for health workers will grow concomitantly. Adopting a strategy of self-sufficiency would aim – over the long term – to develop a countries’ HRH capacities to train and developed their own health workforces, and

thereby reduce their dependence upon unstable international markets for their health professionals. Memoranda of understanding among jurisdictions limiting “active” recruitment strategies and upper limits for salaries and recruitment incentives would help contain competition-induced cost escalation inter and intra-Regionally.

Workforce self-sufficiency as the ‘policy of first response’ encourages economic and infrastructure development, security and independence and stimulates continuing labour and population growth.

v) **Primary Health Care – ‘No one size fits all’.**

A variety of primary health care models are being embraced world-wide. For example, one hundred and fifty-five different models of PHC delivery were identified by the Canadian National Physician Task Force in 2005. However, few have been thoroughly evaluated. The HRH components of these models vary from costly to efficient and from traditional to innovative. It is critical that the necessary and sufficient conditions for individual model success are identified so that communities can make better informed decisions in selecting the most appropriate PHC models available and can adapt them to meet their needs, tailored to their program priorities, capacities and resource availability.

vi) **Health Services Utilization**

Ideally health care utilization matches the health care needs of the population. In reality, medical fashion and practitioner induced demand and public expectations for care can lead to inappropriate or overutilization (and even underutilization) of the health care delivery system. It has been estimated that between of 10 to 20 percent of health care costs may be the result of the inappropriate, ineffective or inefficient utilization of health services.

Health service protocols, health worker performance and accountability measures, new monitoring and evaluation mechanisms, and improved public communication and education are needed. This oversight would help curtail the trend and ensure that necessary health services are provided by the right provider, in the right way, to the right person in the right place, as efficiently and as effectively as possible. This is especially important in the context of increased service demands as the result of increased public access through universal health coverage. Introducing new models of care will provide the opportunity to begin to correct this occurrence through new health care provider incentives and funding mechanisms, new professional roles, protocols and accountabilities, as well as new public expectations.

vii) **Capable and Stable Government Sector**

While considerable attention is paid to the role of the health workforce in providing needed health services, the importance of technical and administrative human resources is often overlooked. Government employees, who are expected to implement, manage and monitor new government programs, often lack the appropriate knowledge, skills and training to carry out their duties. When employee roles are unclear, positions are ill-defined, working conditions are unsatisfactory, pay is low, vacancy and turnover rates are high and departments are understaffed and underfunded, the success of policy and program implementation will be compromised.

The overall size and complexity of the health system makes it slow or even resistant to change. Attempts to micro-manage the system often further exacerbates the situation. Greater success may be achieved through creating more stringent accountability measures and more innovative incentive mechanisms while concurrently creating more administrative freedoms and program

flexibility for managers and health providers to achieve defined budgetary goals and service delivery performance targets.

viii) **Governance**

Strong governance mechanisms – goals, plans, policies, programs, legislation, rules, regulations, directives, guideline, standards and initiatives – must be in place to ensure identified directions, commitments, roles, responsibilities and accountability, are adhered to with respect to program implementation, management, monitoring and evaluation. Mandated standards and guidelines must be set out and clearly understood to ensure that all new policies and programs around UHC are carried out efficiently and effectively but being tailored to the specific priorities and capacities of individual countries. A *change management* works most effectively in an environment where well-defined integrated and consistent governance mechanisms are established,

ix) **Leadership and Political Support**

Strong inter/ intra-governmental support is required to provide the necessary leadership and to maintain the political momentum necessary to implement UHC. Where possible, it should transcend partisan interests and represent a long-term government-wide, health and social agenda. Intra-regional support, collaborative planning and sharing of international best practices, also add strength and acceptability to individual country initiatives. The plan must be an integrated component of government's business plan and long-term economic developmental strategy. UHC, in terms of its scope, requirements and comprehensiveness of coverage must be aligned with government's fiscal capacity.

A commitment to increase the overall investment in the health sector will be required. The 2005 meeting in Abuja recommended that health represent at least 15 percent of total government expenditure. Currently, HRH represents about 30 percent of the health budget globally. These investment levels will need to be increased and stabilized if UHC targets are to be achieved.

x) **Donor Support Coordination**

Many of the countries introducing UHC will be dependent upon donor support for implementation. While disease-specific donor assistance has had a significant impact on population health, the presence of and competition for donor funding has sometimes meant that countries neglect the development of their own health strategies in order to support donor programs and priorities. Local health workforces are destabilized and shortages are exacerbated when incentives are offered to lure health professionals from their current jobs to support donor programs and initiatives.

Improved accountability and coordination of funding among various donors is required so that it is not competing or working at cross purposes with country plans and programs. If donor funding was more supportive of - and better aligned with - government business plans and health service strategies, it would enhance the outcomes and accountability of both government and donor interventions. Emphasizing and supporting PHC development, would, for example, both enhance donor capacity to meet disease-specific program objectives, and, increase the efficiency, effectiveness and long-term sustainability of the overall health care delivery system. Donors are expected to have critical ongoing roles in all phases of UHC development and implementation.

IMPROVING HEALTH CARE ACCESS

In order for rural and vulnerable populations to receive more equitable access to quality health services, the health workforce will need to be further strengthened and better supported to ensure maximum relevance, effectiveness and efficiency. The most effective way to enhance the overall management of the health workforce in achieving these goals is to implement them within a primary health care model. Furthermore, the optimal approach to support the delivery of effective and sustainable primary health care services implementation, is under the integrated and supportive policy umbrella of universal health coverage.

Primary Health Care

Primary Health Care is defined as a set of universally accessible first-level services that promote health, prevent disease, and provide diagnostic, curative, rehabilitative, supportive and palliative services. It is the first level of contact of individuals, the family and community with the national health system bringing health care as close as possible to where people live and work, and constitutes the first element of a continuing health care process.

Primary health care promotes access of vulnerable groups to health care by through expanded health promotion and disease prevention activities that specifically address the chronic conditions of aging and the lifestyle issues associated with non-communicable diseases. Primary health care provides a mechanism to integrate health professional services at the community level. It provides team-based care that allows staff to be deployed and utilized more effectively and efficiently at their full competency levels. It also allows for a more flexible system for patient case monitoring and management to be developed. A staff mix that is flexible and responsive to local needs frees up physicians to attend to more critical patient health issues.

As such, it also provides more innovative options with respect to health delivery models, funding mechanisms and incentive systems. This degree of flexibility provides a greater range of patient contact, health delivery responsibility and continuity in patient care. Greater opportunities for a multi-disciplinary approach to comprehensive care promotes greater productivity and job satisfaction for health for health providers, as well as greater patient satisfaction regarding the quality of health service delivery.

The primary health care delivery model also provides opportunities for linkages to other health service organizations and community services, volunteer organizations and family participation in care management. Working closely with communities, health providers are more closely linked to community health issues and population health needs and trends. Because they are community-based and are often recruited from local communities, primary health care providers are often more sensitive to the local needs of various cultural, ethnic and religious groups. Professional training curricula and continuing education programs for primary health care workers emphasize the kinds of competencies required to address these local needs.

Care for *chronic non-communicable diseases* (NCDs), such as cardiovascular disease, diabetes, cancer, etc., is a global concern, growing far faster than communicable diseases and accident rates combined. The *Innovative Care for Chronic Conditions (WHO, 2013) report* emphasizes that a chronic care model for the management of NCDs is most effective within the integrated approach of PHC programs and service delivery. PHC has a central role to play as a coordination hub, but must be complemented by more specialized and intensive care settings, such as diagnostic labs, specialty care clinics, hospitals and rehabilitation centers to address

specific NCD treatment issues. PHC-led networks of care, with improved clinical information systems, support continuity of quality, evidence-based, patient-centered care to respond to chronic conditions. The reconfiguration of the health workforce into multi-disciplinary teams to better support PHC delivery provides the mechanism for the continual strengthening of a holistic approach to NCD prevention and management.

The broad approach to primary health care delivery described above promotes community policy dialogue and increases stakeholder participation in policy and program development, encompasses NCDs and identifies the core, supportive changes required of the health workforce that will result in a more relevant, viable, equitable and sustainable health system to meet future population needs.

Current Challenges

The *Renewing Primary Health Care in the Americas (PAHO/WHO)* 2013 report reiterated that, in the face of new challenges, knowledge and contexts, there is a growing need to renew and reinvigorate PHC in the Region in order to meet emerging health system challenges. PHC renewal needs to emphasize access, financial fairness, political commitment and the development of systems that assure high quality care. Since system-wide changes are needed, a renewed approach to PHC must make a stronger case for a reasoned and evidence-based approach to achieving universal, integrated and comprehensive care.

From an HRH perspective, the principal challenges that are identified in renewing PHC include:

- i) motivating health professionals and compensating them appropriately;
- ii) obtaining sufficient numbers of HRH to provide UHC;
- iii) building capacity for teamwork;
- iv) an appropriate professional and geographic distribution of HRH;
- v) adequate support and supervision;
- vi) aligning health professional training with the requirements of PHC practice; and,
- vii) addressing the international migration of health workers.

There are also significant implications for HRH in designing a health system based on PHC. Providing UHC will require a critical mass of health professionals trained in PHC to meet population health needs. HRH training and competencies must be linked to identified current and future health care needs, and HRH policies must be comprehensive and multi-disciplinary. In addition, the scope of the HRH workforce must be expanded to include not only clinicians but those working in community support systems, management and administration of services.

Universal Health Coverage

Universal health coverage (UHC), aims to ensure that all people – without distinction of race, religion, political belief, economic or social conditions - can have equitable access to promotive, preventive, curative, rehabilitative and palliative health services they need, of sufficient quality to be effective, while also ensuring that the use of these services does not expose the user to financial hardship. UHC is based on the principles of affordability, accessibility, acceptability and availability.

Universal health coverage provides a consistent policy umbrella for the better management and coordination of the health system in general and the delivery of *primary health care* in particular. Reflecting the goals and values of primary health care, universal health coverage provides a solid policy and planning base for primary health care delivery.

With an integrated and coordinated policy approach, UHC provides a *change management framework* that identifies key players and relevant change agents and defines individual roles and accountabilities in the implementation of the primary health care model. UHC provides a long-term vision for planning the health system, for strengthening the health workforce and for improving access to care. It provides a supportive framework to develop innovative funding models and health worker incentives to support coordinated and collaborative workforce development.

It also provides a broad-based mechanism to rationalize and better coordinate the roles of the public and private sectors in the provision of health care. The effective implementation of primary health care requires a comprehensive and coordinated governance framework to minimize professional regulatory and accreditation barriers and maximize opportunities for innovative health care delivery. The UHC approach facilitates the development of a sound policy, legal and institutional backdrop that identifies and empowers the actions, actors, procedures and legal and financial systems that allow PHC to perform its specified functions.

The UHC framework, supported by community-based PHC, allows for a more responsive and precise definition of health care needs across all social sectors. As such, it also provides stronger mechanisms for better aligning the content and output of the health education system with the needs of the health care delivery system. By offering a more consolidated vision of health care delivery, UHC provides a more consistent vision for health workforce development and support overall. It is also more easily adaptable to changing needs and more capable of be evaluated on an ongoing basis. As such, the presence of UHC with defined system goals and the greater likelihood of service continuity over the longer term, makes countries a more attractive investment to donor agencies. Supporting ongoing infrastructure development thus increases the sustainability of both Ministry of Health planning initiatives and donor agency program priorities.

Achieving Universal Health Coverage (PAHO, 2013)

The *PAHO/WHO Strategic Consultative Meeting on Achieving Universal Health Coverage* (September, 2013) identified a number of key challenges in achieving UHC including ensuring sufficient and sustainable financing, improving the quality and efficiency of health systems and guaranteeing comprehensive, integrated health care that includes prevention and health promotion that is available to all. Participants noted that advancing UHC in the region would require advocacy and technical cooperation by PAHO and its member countries in areas including:

- i) establishing a baseline for achieving UHC and measuring and monitoring progress;
- ii) strengthening regulations and legal frameworks for UHC using a human rights approach;
- iii) identifying obstacles to access for vulnerable groups;
- iv) identifying and costing packages of essential services;
- v) building social and political consensus for the goal of UHC;
- vi) gauging public expectation about coverage and quality to ensure a people-centered approach; and,
- vii) addressing the social determinants of health as an essential part of efforts to advance UHC.

It is estimated (*Universal Health Coverage: A Commitment to Close the Gap, 2013*) that the elimination of within-country wealth inequities in coverage of essential maternal and child health interventions would prevent the deaths of 1.8 million children under-five and 100,000 mothers,

reducing child mortality by one-fifth and maternal mortality by almost one-third. With more equitable health financing (e.g. increasing pooled funding as share of national health expenditure by 10 percentage points), under-five mortality rates could fall by 15 deaths per 1,000 live births. In addition, there could be a projected 76 percent increase in the number of countries reaching MDG 4, a two-thirds reduction in the number of children dying by their fifth birthday.

Of the twenty-one governance and partnership recommendations that came out of the above report, many had implications for HRH, but only one pertained directly, to “align provider incentives with equity objectives including the provision of sufficient and timely reimbursement, fair wages and resources to cover recurrent costs.”

The *World Health Report: Financing for Universal Health Coverage* notes that 20 to 40 percent of resources spent on health are being used inefficiently and opportunities to achieve more with the same resources exist in all countries. Getting the most from technologies, better motivated health workers, improved hospital utilization, a reduction in medical errors, eliminating waste and corruption and a critical assessment of which services are needed, would greatly improve overall health system efficiency in many countries.

In summary, a system of UHC provides an opportunity for strong leadership with respect to how the health system is funded, who is funded, what is covered and how it will be delivered in a more integrated and cost-effective way. Addressing issues of differential access to services for disadvantaged groups is a key feature and strength of this approach.

Country Experiences

Many countries, both regionally and globally, have reported important improvements in health status and life expectancy which are attributed to progress in social determinants of health and to implementation of a comprehensive national health system with strong social participation.

As a result of significantly expanding their health coverage in recent years, a recent study of six countries in the *Region of the Americas* reported that inequities in health service utilization has declined over time (Brazil, Mexico and Chile); important progress has been made in the overall quality of health-care service delivery (Colombia); and, equities in the utilization of curative services in particular have recorded significant improvements (Peru).

Several success stories – including Sudan, Cameroon, Thailand, Ghana and Indonesia – have resulted from efforts to improve the availability, accessibility, acceptability and quality of the health workforce, with corresponding improvements in health outcomes. Both Rwanda’s performance-based payment to health workers, and Ethiopia’s health extension program, have also been heralded as successes. More detailed, select country examples are included below.

Argentina

In response to the economic crisis of 2001, the Government of *Argentina* implemented the innovative Maternal-Child Health Insurance Program, known as *Plan Nacer*, which became a powerful tool in increasing coverage of basic services among the uninsured population and improving the governance and efficiency of the health system.

Specifically, the program links funding to the achievement of three types of results indicators: enrolment in the program, effective delivery of priority health services, and health outcomes. In addition, Plan Nacer contributed to strengthening the governance and stewardship function of

the national government in a federal context where health services provision is decentralized at the provincial level. The program led to improvements in the quantity and quality of services, healthier births, an increase in average birth weight, and a decrease in the likelihood of children being born with very low birth weight and raised the likelihood of well-baby checkups.

The major contributing factors to the programs success were the strategic use of financing to enroll and maintain contact with the target population, contracts with built-in enforcement mechanisms, and a results-based approach that provided incentives for desirable results.

The shift from a traditional, input-based financing scheme to a results-based financing approach helped increase access to basic health services and strengthen governance of the entire public health system. The next important steps will be the development of sound health information systems, monitoring and evaluation tools to assess health sector performance, clinical protocols, addressing issues of program sustainability, equity across provinces, and the need to establish a standardized process for setting priorities that includes clinical and cost-effectiveness studies and social validation mechanisms.

Brazil

The launching of PHC in Brazil, for example, has led to a rapid decline in infant mortality, a rapid rise in immunization, the identification of medical resource utilization bottlenecks and timely crises intervention. Strengthening nursing roles in primary health care have expanded care in poor neighborhoods and rural areas. In most cases, universal health coverage has had a positive overall impact on patient financial protection. Some challenges still remain, however, with respect to: persistent socioeconomic and regional disparities; new health problems related to rapid urbanization; administrative issues do the size and complexity of the health system; more clarity is needed regarding the role of the private sector; more rural HRH support is needed to support the expansion of health promotion; and, the system would benefit from stronger political role and support with respect to PHC and financial re-structuring.

Rwanda

The *Rwanda HRH Program* was launched in 2012 with the aim of meeting citizen health needs by 2020. It represents a new model for health education and the delivery of foreign aid. Funded directly by the US government, the Ministry of Health has partnered with a consortium of 23 top US Institutions of medicine, nursing, health management and oral health. By supplying full-time faculty who are paired with Rwandan faculty and students to ensure knowledge transfer and the upgrading of clinical skills, the US institutions have made a commitment unprecedented in global health. Over 500 physicians and 5000 nurses will have their skills upgraded. Two new degree programs (health care administration and global health) will also be introduced that focus on financial management and leadership. After seven years Rwanda will be able to sustain the improved health workforce without foreign aid.

India

India's health care system is struggling with the complexities of multiple disease burdens, escalating costs and persistent HRH shortage and distribution issues. In order for India to achieve its *Vision 2022 for UHC*, the key elements of the process are to conduct a situational analysis of HRH, project future requirements and address challenges in production, retention and performance, and, fiscal sustainability, including costing the plan. The main thrust of the HRH retention policies is to develop comprehensive monetary and non-monetary incentives to retain qualified health personnel in underserved areas, appropriate HRH governance mechanisms and uniformity of pay structures across the states.

Australia

Increasingly, health workforces are undergoing high-level 're-engineering' to help them better meet the needs of the population, workforce and service delivery. Queensland Health in *Australia* implemented a large scale 5-year workforce redesign program across more than 13 health-care disciplines. The study synthesized the findings from this program to identify and codify mechanisms associated with successful workforce redesign to help inform other large workforce projects.

Three overarching principles were identified that optimized successful workforce redesign: (1) drivers for change need to be close to practice; (2) contexts need to be supportive both at the local levels and legislatively; and (3) mechanisms should include appropriate engagement, resources to facilitate change management, governance, and support structures. Attendance to these factors was uniformly associated with success of individual projects.

Turkey

In 2003, Turkey's infant and maternal mortality rates were among the highest in the region, while life expectancy was 10 years below the OECD average. Despite fiscal difficulties and double-digit inflation, Turkey reformed its health care in order to become more economically competitive. Currently, formal health insurance covers more than 95 percent of the Turkish population. Infant mortality has dropped over 40% since 2003. And three-quarters of the Turkish population indicate that they are satisfied with their health services.

Ethiopia

When Ethiopia launched its free universal primary care program in 2003, at its center was a network of health extension workers. Over 35,000 women, with high school education recruited from their communities, were trained for one year and redeployed back into their communities. The latest survey data show that child mortality fell by over one quarter, as did child stunting. For women, anemia rates fell and contraceptive use nearly doubled, helping to reduce the total fertility rate.

Conclusion

It is important to note that the various health policy pathways above have varied in accordance with the needs, contextual factors and opportunities specific to each country's setting. But long-term success in all jurisdictions is highly contingent upon having high-level political support to ensure alignment and coordination of the various sectors to sustain HRH development efforts.

In 2013, the *World Bank* identified five lessons from their case studies in 27 low and middle income countries with respect to their experiences with universal health coverage:

- i) Strong national and local political leadership and long-term commitment are required to achieve and sustain universal health coverage;
- ii) Short-term wins are critical to secure public support for reforms. For example, in Turkey, hospitals were outlawed from retaining patients unable to pay for care;
- iii) Economic growth, by itself, is insufficient to ensure equitable coverage. Countries must enact policies that redistribute resources and reduce disparities in access to affordable, quality care;
- iv) Strengthening the quality and availability of health services depends not only on highly skilled professionals, but also on community and mid-level workers who constitute the backbone of primary health care; and,

Countries need to invest in a resilient primary health care system to improve access and manage health care costs.

Recently, at the *66th World Health Assembly*, Health ministers from the Americas vowed to continue to work towards universal health coverage. Delegates spoke of placing health at the center of public policies to advance country development; noted that the next generation of development goals should include overcoming gaps in equity; emphasized the need for strong political leadership; and, stressed that the future international development agenda must take into account the interdependence of health, human welfare and economic development. Improving maternal and child health, and addressing non-communicable diseases through the continued development of health promotion and disease prevention strategies were identified as high priorities.

This kind of leadership platform and acknowledgement of the scope of the level of comprehensive support that is required to move the HRH agenda forward, augers well for strong, continued progress in the pursuit of universal health coverage.

HUMAN RESOURCES FOR HEALTH PLANNING

Role

Human resources for health (HRH) planning aims to ensure that there are enough health workers to meet the health care needs of the population. The general purpose of HRH planning is to provide the appropriate information and tools needed for decision-makers (governments, health regions, training institutions, managers) to make informed, strategic decisions in HRH planning, training and deployment to ensure that the health care delivery system is effective, affordable and sustainable.

Having the right supply, distribution and appropriately deployed health workforce is critical to having an effective and efficient health care delivery system. Policies on recruitment and retention, education and training, licensure, safety and deployment all impact on the availability of HRH and on the overall stability and efficiency of the health workforce. The outcomes of the health care delivery system depend to a large extent on having a workforce that is appropriately trained, deployed, supported and accountable.

Without appropriate corrective policy action to improve population access, inequalities in health related to geography, age, gender, ethnicity, educational level and income distribution will continue to grow unabated.

Universal health cannot be fully achieved and sustained without a comprehensive, integrated and evidence-based PHC delivery system, supported a competent, motivated, efficient, effective and appropriately distributed health workforce. Similarly, a well-developed UHC system is not only dependent upon - but also supportive of - the continued strengthening of PHC systems and health workforce. Since UHC requires a high-functioning, optimal and stable workforce, governments must be more supportive (politically and administratively) of the kinds of holistic, broad-based HRH policy changes that are required (governance, management, education and training, etc.) to ensure that the health workforce is manageable and sustainable over the longer term.

Thus, while HRH, PHC and UHC tend to be mutually dependent to be optimally effective, the bottom line is that “*there is no health without a workforce.*”

HRH Plans and Initiatives

A number of historical initiatives have helped build Regional HRH planning and management capacity:

- i) In 2005, the *Toronto Call to Action of Human Resources in Health in the Americas* (2006-2015) aimed to mobilize the health sector to collectively strengthen HHR in order to achieve the Millennium Development Goals and provide quality health services for all the peoples of the Americas by the 2015;
- ii) HRH *Observatories* in the Americas have helped to produce information and evidence to inform policy decisions to improve health systems through health workforce development;
- iii) The *Health Agenda for the Americas 2008-2017*, launched in 2007 by the Health Ministers of the Region, emphasized the need to strengthen the management and development of the health workforce;
- iv) In 2007, the countries of the Region began the *Data Management Project* to develop a core data set for HRH, to better monitor, manage and evaluate Human Resources for Health;
- v) In 2007, twenty *Regional Goals for Human Resources for Health (2007-2015)* were ratified and provided a regional orientation for analysis and formulation of workforce planning priorities in line with the needs and priorities of each country; and,
- vi) Between 2008 and 2012, *Regional HRH Goals Reviews* were undertaken across the Region to determine the degree of progress had been achieved by countries in achieving their respective HRH planning targets.

Regional challenges included strengthening HRH planning capacity, workforce geographic distribution, migration strategies, workplace health and safety and the alignment between training institutions and the needs of the health system.

PAHO Resolution on HRH (2013)

A policy document was recently produced by PAHO emphasizing the need to increase access to qualified health workers in primary health care-based health systems. The paper identifies a range of reforms and policy orientations needed to achieve that goal, including: i) strengthening capacities for the planning of HRH; ii) reforming health professional education to support better quality PHC-based health systems and progress towards UHC; and, iii) empowering people-centered, community-oriented collaborative PHC teams.

The resolution proposed by the *Directing Council* (CD52/6) urges member states to:

- i) reiterate their commitment to achieve the 20 regional goals for HRH;
- ii) empower and support PHC collaborative multi-professional teams;
- iii) identify and monitor health professional shortages;
- iv) invest in the production, utilization and analysis of core data on HRH;
- v) promote the social mission and accountability of health sciences education and accreditation centers with respect to PHC and UHC;
- vi) reform graduate medical education to support PHC-based health systems;

- vii) introduce and evaluate incentive schemes to recruit and retain health workers in remote and underservice areas; and,
- viii) reiterate their commitment to the WHO Global Code of Practice on the International Recruitment of Health Personnel.

In addition, the resolutions also included a recommendation to: “establish and strengthen a strategic planning and management Unit for Human Resources for Health with the capacity to lead, engage and generate consensus among national education authorities, academic health centers, and community organizations on current and future HRH needs, in particular for PHC-based health systems.”

This resolution further emphasizes the critical need to develop the HRH planning and policy development function within regional Ministries of Health in order to successfully implement and support PHC and UHC systems.

Global Forums on Human Resources for Health

Kampala (2008)

The 1st Global Forum on Human Resources for Health was held in Kampala, Uganda in 2008. It called for immediate and sustained action to resolve the critical shortage of health workers around the world. Attendees at the Forum endorsed the *Kampala Declaration* and the *Agenda for Global Action* as instruments for alignment and accountability a global, regional, national and local levels regarding the accelerated implementation of comprehensive HRH plans.

Bangkok (2011)

Building on this momentum, the 2nd Global Forum on HRH in Bangkok (2011), further emphasized that a robust health workforce is a core element of health systems in all countries and critical to achieving the Millennium Development Goals and Universal Health Coverage.

The 2nd Global Forum noted that: i) the supply of HRH remained inadequate and access to services inequitable for marginalized people; ii) HRH data was inadequate; iii) leadership and regulatory frameworks needed to be strengthened; iv) workforce coordination mechanisms among stakeholders were lacking; v) stronger national capacity to support policy-making, planning and management was needed; and, vi) more attention was needed on the distribution, retention, competency and composition of the health workforce.

A key advancement in HRH included the adoption of the WHO Global Code of Practice on the International Recruitment of Health Personnel in 2010. The Global Strategy for Women’s and Children’s Health identified the need for significantly more health workers to achieve MDGs 4 and 5.

Recife (2013): A Call to Action

The theme for the 3rd Global Forum, held in Recife, Brazil in 2013, was *Human Resources for Health: foundation for Universal Health Coverage and the post-2015 development agenda*. Building on the Kampala Declaration, the Recife *Call to Action* urged all stakeholders and the international community to provide support and foster collaboration at all levels, working together towards the shared vision that “*all people, everywhere have access to a skilled, motivated health worker, within a robust health system.*”

The *Recife Declaration* on HRH outlines the critical actions and commitments required at national and global levels to address international challenges, key among them is the issue of migration. Measures listed are linked to increasing financial resources while others focus on improving the use of existing resources through improved governance, improved management and performance, tasks sharing, better equality and accessibility, improved training and better distribution and retention of existing staff. It emphasizes the importance of strengthening HRH information systems, adopting innovative solutions and investing in research. While broad themes and approaches were identified, each country will have to take appropriate, specific measures according to its own political, fiscal and social priorities.

An HRH commitment template was developed by the Global Health Workforce Alliance and the WHO Secretariat to serve as an advocacy instrument, facilitating policy dialogue around relevant pathways for evidence based HRH actions. As a result, 70 HRH commitments were presented by countries and other stakeholders attending the forum.

Within the Region of the Americas, 13 countries presented their HRH commitments, identifying a range of specific actions and priorities:

- *Argentina* is committed to strengthening integrated health education policies, training health technicians, with a focus on improved population access to training and services;
- *Belize* emphasized health policy (working conditions and regulatory guidelines), improving HRH management capacity, aligning professional training with the needs of the population, developing evidence-based budgets, and improving leadership and partnerships with donors, NGO's and the private sector;
- *Brazil* is recruiting multi-task CHWs, Health Inspectors and auxiliary Nurses to respond to community needs, improving education and training technologies, strengthening training school management, and emphasizing maternal and child health, NCDs and public health;
- *Chile* is implementing operational plans of the 2013-2020 National HRH Policy at central and local levels, updating it biannually, emphasizing quality, comprehensive community care, equitably distributed based on population health needs and priorities;
- *Columbia* is strengthening the focus on PHC, producing 4000 more family physicians over the next decade, and emphasizing continuing education, strengthening the skills of health technicians and aligning health professional responsibilities with population needs;
- *Dominican Republic* is monitoring HRH progress carefully, strengthening professional standards and competencies, implementing a model of efficient HRH management, including improving managerial skill sets in planning and strategic management in both HRH and PHC sectors in support of UHC;
- *Ecuador* aims to strengthen the capacity of its health workforce by improving hiring practices, increasing wages and incentives schemes, a workforce recruitment and retention plan and a multi-year training program to produce over 10,000 health professionals;
- *El Salvador* continues to monitor and assess progress towards reaching the 20 Regional HRH goals, implementing the National Policy for Development of HRH, strengthening HRH planning, aligning health workforce and training with population needs, promote life-long learning, improved working conditions and the development of information systems and knowledge to support planning;
- *Guatemala* increasing numbers of midwives and nurses to work in community centers, hiring new physicians to work in hospital services, rotating in priority areas (health

centers, anaesthesiology, radiology and pathology), aiming to decrease nursing attrition by 20 percent, medical specialty programs being reviewed and updated, wages being increased, a Strategic Plan is being developed that includes health and safety, performance and quality management and job satisfaction;

- *Paraguay* is supporting continuing education regarding HRH technical and managerial competency development, and is implementing telemedicine to improve HRH skills;
- *Peru* is introducing a new comprehensive remuneration policy based on merit, performance and risk by level of care; improving the quantity and quality of HRH at national and local levels; introducing non-monetary worker incentives in less-resourced areas, strengthening competencies in PHC and HRH information systems development.
- *Suriname* is committed to national policy development, emphasizing health education and training; increasing the overall number of nurses in training; and in-house hospital training, emphasizing specialized areas for infection and chemotherapy.
- *Uruguay* is strengthening the capacity of their HRH Observatory; better aligning the goals of professional regulatory bodies and the HRH strategies of government; and, developing a nursing workforce policy to address population health care needs.

As evidenced by the initiatives listed above, many countries within the Region of the Americas have taken significant steps to strengthen the capacity and efficiency of their health workforces and to expand and support the delivery of community-based PHC services. This provides a strong foundation and continued momentum for ongoing intra-Regional collaboration in health workforce development.

As such, the key result of the Third Global Forum was to bolster political commitments on HRH, based on technical evidence, in order to accelerate progress towards Universal Health Coverage.

A Universal Truth: No Health without a Workforce

Developed for the 3rd Global Forum on HRH, this GHWA/WHO document aimed to consolidate what is known about HRH and how to attain, sustain and accelerate progress towards achieving Universal Health Coverage.

The *Universal Truth* document (UT) identifies a number of ongoing HRH challenges:

- almost half the countries in the world have significant shortages of HRH;
- the workforce is ageing and replacements remain problematic;
- skill-mix imbalances persist and many health workers are deployed sub-optimally;
- accessibility and attracting and retaining health workers remains a problem;
- adapting education strategies and the content of pre-service education is a major challenge;
- health workers need to be kept motivated in an enabling environment;
- performance assessment and quality of care need to be higher priority;
- country capacity to plan, forecast and undertake policy development is limited; and,
- HRH information data systems need strengthening and greater investment.

While there is currently an estimated global deficit of about 7.2 million skilled health professionals (midwives, nurses and physicians) in 100 countries, the number is expected to grow to almost 13 million over the next 20 years.

Given the acute shortages in HRH, a number of countries have responded with innovative approaches to expanding the quality of health coverage, which include: i) expanding the role of community health workers (e.g. health extension workers in community outreach programs in Ethiopia); workforce innovations in health care delivery models (e.g. teaming health professionals with community-based health workers); scaling up educational systems to serve underserved communities (e.g. Bangladesh has seven set up seven diploma training sites in remote areas to improve rural student access); and, harnessing information and communication technology to improve service quality and access (e.g. Rwanda has implemented two e-health initiatives to raise the capacity of health workers).

Similar HRH progress and challenges are identified in the UT profiles of 36 countries, five of which are within the Region of the Americas (Brazil, Cuba, Mexico, Nicaragua and Peru).

- i) **Brazil** has had universal access to health care since 1988 under the Unified Health System (SUS) but private expenditure is 55 percent of total health care costs. It has a nurse to physician ratio of 3.6 (above the OECD average), and overall availability of HRH is good, although the density of physicians varies six-fold between urban and rural areas. The Mais Medicos (More Doctors) program was launched in 2013 to fill rural PHC vacancies. There is no national HRH long-term plan. Infant mortality rate is 10 per 10,000, maternal mortality rate is 56 per 100,000 live births.
- ii) In **Cuba**, the government is responsible for 95 percent of health expenditures. Universal access to health care is provided free of user charges. About 80 percent of health problems are dealt with through PHC. Ratio of nurses to physicians is 1.3 and everyone has access to a family physician. Ratio of physicians is twice as high in urban areas compared to rural areas. The density of skilled health professionals is over 30 percent higher than the US rate and almost double that of Brazil. There is only a partially completed HRH strategic plan. The infant mortality rate is 5 (per 10,000) and the maternal mortality rate is 73 (per 100,000).
- iii) In **Mexico** access to health care is linked to employment status. The contributory subsystem, funded by employers and employees, is mandatory for salaried workers and covers 47 percent of the population. Out-of-pocket payments represent 49 percent of total health expenditure. The ratio of nurses to physicians (1.9) is below the OECD average. There are various HRH strategies but no formal plan. Rural distribution of physicians remains a problem. The infant mortality rate is 13 per 1,000 live births, and the maternal mortality rate is 50 per 100,000 live births.
- iv) In **Nicaragua**, a social health insurance mechanism covers about 18 percent of the population. The current density of skilled health professionals is about half the minimum recommended level. The density of physicians per 10,000 population is about seven times higher in urban areas compared to rural districts. The ratio of nurses to physicians (2.9) is above the OECD average, but there is a scarcity of nurses overall. Infant mortality rates at 22 (per 1,000 live births) and maternal mortality rates at 95 (per 100,000 per live births), remain high. There is a national HRH strategic plan to begin to address these issues.
- v) In **Peru**, about 90 percent of the population is covered publically. The Integral Health Insurance covers workers, self-employed and the unemployed and their families; with basic health services defined locally in a decentralized health system. The density of skilled health professionals is currently below the minimum standard.

Geographical HRH imbalances also remain critical. While there is a national HRH strategy, the quality of information systems and health professional education and practice, needs strengthening.

It is clear that a more integrated and comprehensive approach to address the identified HRH issues is needed across the Region to achieve sustainable solutions over the longer term. The UT report presents a **10-point agenda** as the conditions for success in improving the four main dimensions of the health workforce – availability, accessibility, acceptability and quality - in line with the broad principles of universal health coverage.

- Recognize the centrality of HRH in achieving UHC and in improving health care.
- Assess the gap between the need and the supply of HRH.
- Formulate HRH policy objectives that encompass the health system vision.
- Build the data, evidence base and strategic intelligence to monitor/manage progress.
- Build the technical capacity to design, advocate for and implement policies.
- Build political support at the highest level to ensure continuity towards achieving UHC.
- Reform the governance and institutional HRH environment.
- Assess the cost of the various HRH reforms.
- Encourage international partners to support health system capacity building.
- Encourage international partners to address transnational HRH issues collaboratively.

The *World Health Report 2000* stated that HRH are the most important of the health system's inputs. As such, the UT report further emphasizes that political and technical leadership is critical in order to seize the opportunity to attain, sustain and accelerate progress on universal health coverage by transformative action on HRH.

WHO Bulletin: Human Resources for Universal Health Coverage (2013)

Health workforce development is partly a technical process and, as such, it requires expertise in human resource planning, education and management. It also requires a political process requiring the will and the capacity to coordinate efforts on the part of different sectors, constituencies and levels of government.

The WHO Bulletin provides examples of how countries have aligned both these aspects by presenting new analytical tools and evidence surrounding successful or promising innovative approaches. It contributes to strengthening the policy frameworks and evidence base surrounding HRH by: i) providing insights into market forces affecting HRH, ii) highlighting best practices in HRH policy, iii) providing new evidence on the effectiveness of mid-level and community-based health workers, and, iv) by identifying opportunities for innovation in HRH education and management support through the use of emerging technologies.

Other strategies recommended include moving from: i) a global to a country-specific approach to strategy development, ii) from short-term solutions to long-term system building, iii) from public-sector-centric to a comprehensive labour market approach, iv) from traditional health education model to a modernized production system, and, v) towards greater investment in building knowledge and in a comprehensive data system.

With the theme of “Human Resources for Universal Health Coverage”, this special edition of the Bulletin highlights a number of articles on HRH research, policy and practice, lessons from the field, as well as round table discussions and perspectives, that provide a range of relevant

background information and insights on ways to approach and address HRH issues to better support the implementation of universal health coverage.

A summary of some of the articles key observations are set out below.

- i) **Remuneration** - While health workers generally account for about one-third of countries' total health expenditures, and as a whole, has been decreasing over time. Countries will need to devote an increasing proportion of the GDP's to health and health worker remuneration as they seek to attain universal health coverage.
- ii) **Who Global Code of Practice** – Reporting on the implementation of the Code has been sub-optimal and an international, comparative information base on HRH mobility needs to be collaboratively developed. Greater awareness, including political and technical commitment, is needed regarding the Code's relevance as a potent framework for policy dialogue on ways to address the health workforce crisis.
- iii) **Quality of Care and Mid-Level Health Care Workers** – While the quality of evidence was low, the review did indicate that there was no difference between the effectiveness of care provided by mid-level health workers and that provided by higher levels of health workers in the areas of communicable and non-communicable diseases and maternal and child health. Women were significantly more satisfied with the care from midwives. Mid-level and community health worker roles should be clearly defined in relation to emerging health service needs.
- iv) **Community Health Workers** - Inconsistent support of CHW and failure to integrate them into the health system has impeded the realization of their potential contribution in the context of PHC. Strong leadership is needed from the public sector to address a host of challenges regarding CHW programs (poor planning; multiple competing actors with little coordination, supervision and support; fragmented disease-specific training; donor driven management and funding; and, tenuous linkage with the health system) and to invest in building CHW's skills and supporting them as valued members of the health care team.
- v) **Retention in Rural and Remote Areas** – The WHO issued global policy recommendations to improve the rural recruitment and retention of the health workforce. At the country level (Lao People's Democratic Republic and South Africa), the guidelines facilitated a focused policy dialogue which resulted in the development and adoption of more relevant and evidence-based policies. More research and impact assessment is needed on the link between rural availability of health workers and universal health coverage. The effects of health financing reforms on incentive structures also need to be assessed with respect to the equitable distribution of health workers.
- vi) **Health Labour Market Forces** – Estimating health workforce requirements is traditionally based on population epidemiological and demographic profiles, ignoring labour market dynamics and behavioral responses and preferences of health workers themselves. A better understanding of the impact of health policies on health labour markets, and subsequently on the employment conditions of health workers, would be helpful in identifying effective strategies to achieving universal health coverage.

- vii) **Fostering Equity and Effective Coverage** – There are a number of HRH policy lessons that can be learned from four countries that achieved sustained improvements in UHC: *Brazil, Ghana, Mexico and Thailand*. Policy actions were traced regarding national trends in workforce numbers and population mortality rates in relation to the analytical framework dimensions of availability, accessibility, acceptability and quality of HRH. It was concluded that: i) HRH are critical to the expansion of health care coverage and the package of benefits; ii) HRH strategies in each of the dimensions above collectively support achievements in effective coverage; and, iii) success is achieved through partnerships involving health and non-health actors.
- viii) **Strengthening HRH through Multi-Sectoral Approaches and Leadership** – *Cameroon* has a severe shortage and inequitable geographic distribution of HRH. Between 2007 and 2009, the active health workforce increased by 36 percent, several new training institutions were opened and a national strategy for UHC was developed. Strong national leadership is needed to ensure effective coordination and communication between diverse stakeholders to produce a consensus view on the HRH challenges and the evidence-based plans to address them.
- ix) **Information, Coordination and Accountability** - HRH in *Sudan* is critical in terms of supply, distribution, retention, management and planning information. A “country coordination and facilitation” process was implemented to strengthen the observatory, provide a platform for key stakeholders, catalyse support for policy and planning, harmonize mobilization of resources, strengthen HRH managerial structures, establish new training institutions and scale of training of CHWs. An information system was established and evidence-based decision-making was implemented. Leadership, coordinated stakeholder support and shared accountability in planning and implementation, has resulted in stronger political support and the mobilization of resources in support of HRH.
- x) **HRH and Health System Development** – To address low health service coverage in the 1980’s, *Thailand* introduced measures to reduce geographical barriers to service, improve district infrastructure, make essential medicines more widely available, expand financial risk schemes and develop a competent and committed workforce to work in rural areas. District hospitals, PHC services and the health workforce were greatly expanded. By 2002, Thailand had achieved UHC. The holistic development of a committed, integrated workforce with a strong policy focus was key to the success.
- xi) **Setting Targets and Measuring Progress**- The attainment of UHC will not only depend upon the availability of adequate numbers of HRH, but also on the distribution, quality and performance of the available health workforce. Required inputs from HRH are changing with growing importance of NCDs. New HRH benchmarks and corresponding monitoring framework need to be developed and included in the UHC agenda. Benchmarks need to be more diverse and more fully recognize the roles of CHWs and mid-level health workers, and emphasize equity in accessibility, gender composition and quality in HRH development.
- xii) **Round Table Discussions on HRH and UHC** –
- i) Reliable and comparable health workforce statistics are essential and countries and global partners need to invest more in health workforce

- registries, census of health facilities and in strengthening country analytical capacity.
- ii) A post-2015 development agenda for HRH will require an accompanying accountability and reporting mechanism for collating data on the availability, accessibility, acceptability and quality of the workforce to meet population needs and to ensure the equitable delivery of quality care.
 - iii) Health workforce benchmarks for measuring sustainable progress towards UHC must reflect basic socioeconomic causes of UHC gaps both within and beyond the health sector, and be sensitive enough to reflect changes in population health and health system developments.
 - iv) Patients and communities need to be empowered to be able to hold health systems and their leaders to be more accountable for setting appropriate staffing and funding targets.
 - v) Support for innovative and sustainable e-learning programs for health workers needs to be established through new public-private partnership models that engage the full range of stakeholders.
 - vi) A health labour market framework is needed to shed light on the range of factors and forces behind health workforce supply and demand, and to ensure that effective health workforce policies are developed.
 - vii) With emerging tools, and a re-orientation of the health system to achieve greater NCD control, health worker roles need to be revised and competencies expanded to maximize the effectiveness of the health system.

The WHO Bulletin calls upon health workforce planners and managers to develop policy formulation and implementation capacities and competencies, utilizing the best evidence available. It also emphasizes the need for the international community to work together on a shared global priority, inspired by the principles of international solidarity, multilateral collaboration and mutual accountability.

Increasing Access to Health Workers in Remote and Rural Areas through Improved Retention – *Global Policy Recommendations (WHO, 2010)*

Globally, approximately one half of the population lives in rural areas, but less than 38 percent of the nurses and less than 25 percent of the physicians work there. While getting and keeping health workers in rural and remote areas is a challenge for all countries, the situation is worse in the 57 countries that have an absolute shortage of health workers. The geographic maldistribution of qualified health workers impedes access to health care service for a significant percentage of the population, slows progress towards achieving the MDGs and challenges the aspirations of achieving health for all.

The WHO document proposes sixteen evidence-based recommendations on how to improve the recruitment and retention of health workers in underserved areas. It also offers a guide for policy makers to choose the most appropriate interventions, and to implement, monitor and evaluate their impact over time. The WHO reports provides recommendations that cover four broad areas; education, regulation, financial incentives and personal and professional support.

The recommendations include:

- **Education:** i) using targeted admission policies to enrol students with a rural background; ii) locating health professional schools and residency programs outside of capitals; iii) exposing undergraduate students in various health disciplines to rural

community experiences; iv) revising training curricula to include rural health topics; and, v) designing continuing education and professional development programs that meet the needs of rural health workers.

- **Regulation:** i) regulating enhanced scopes of practice in rural and remote areas; ii) introducing different types of health workers with appropriate training and regulation for rural practice; iii) ensuring compulsory service requirements in rural areas are accompanied with appropriate support and incentives; and, iv) providing scholarships, bursaries or other education subsidies with enforceable agreements of return-in-service in rural areas.
- **Finance:** Using of a combination of fiscally sustainable financial incentives, such as hardship allowances, grants for housing, free transportation and paid vacations, etc. to make rural practice more attractive.
- **Personal and Professional Support:** i) improving living conditions for rural health workers; ii) providing a good and safe working environment; iii) implementing appropriate outreach activities (including *telehealth*) to facilitate cooperation between health workers in better served and underserved areas; iv) support career development programs in rural areas; v) support the development of rural professional support networks; and, vi) adopt public recognition measures to lift the profile of working in rural areas.

It is also suggested that the health equity principle should guide the development of rural retention strategies and they should be grounded in the national health plan. Assessing options requires HRH management and evaluation expertise while implementation requires engagement of stakeholders. The report recommends that interventions be selected and evaluated on the basis of relevance, acceptability, affordability, effectiveness and impact.

Journal of Human Resources for Health (WHO)- *Recruitment and Retention*

A review of recently published articles (2012-2013) in the *Journal of Human Resources for Health* indicates that individual country experiences are insightful, with regards to improving workforce retention in rural areas, and both consistent with and supportive of the policy directions outlined above in the WHO's Global Policy Recommendations.

- A survey of medical laboratory professionals in seven countries in *sub-Saharan Africa* was conducted to assess the factors responsible for effective staff retention strategies. Professional development/training opportunities was identified as the most important factor by 90 percent of respondents. Those employed in the private sector were less likely to remain in their jobs than those working in the public sector.
- Over 60 percent of the population lives in rural areas in *China*. A survey of almost three thousand doctors revealed that rural doctors felt that the training strategy was inadequate and that retirement pension and income were the most important factors in successful recruitment.
- An overview and synthesis of the current evidence on the effectiveness of interventions to promote nurse retention revealed that the most important strategies were financial incentives, supportive relationships in nursing, information and communication technology, and rural health career pathways.

- Analysis of recruitment strategies for medical students in *Thailand* indicated that ‘special track’ graduates who came from provincial cities, as opposed to Bangkok, were 10 to 15 percent more likely to fulfill their mandatory service commitments.
- A study of nurses in *Lebanon* revealed that retention was low, especially in the hospital sector. Programs targeting professional development opportunities and rural incentive schemes were needed. Rural nurses working in PHC centers exhibited greater job satisfaction than their hospital counterparts.
- A study of rural health workers in *India* indicated that a more comprehensive incentive package (more prestige, not just monetary gains) was needed to retain workers in PHC. Furthermore, rural incentive strategies, when adapted to individual cadres of workers, are expected to be more successful in retaining nurses than doctors.
- There is a shortage of pediatricians in *Japan*, and any increases in pediatrician numbers were centered in urban areas. A crisis situation is expected to arise as pediatricians in rural areas are not being adequately replaced as senior physicians retire.
- A literature review of staff motivation and retention revealed that while financial incentives, career development and management issues are core factors in improving staff retention, monetary rewards are generally insufficient, while staff ‘recognition’ was deemed highly influential in motivating health workers.
- In *Australian* review indicated that non-Australian family physicians had a much greater risk (almost 1.5 fold) of turnover than Australian trained physicians. Physicians with hospital admitting privileges were less likely to leave. Incentive schemes should reflect that family physicians remained in remote locations for an average of three years, while those practicing in ‘small coastal closely settled locations’ stayed about 11 years.
- *Australia’s National Rural and Remote Health Workforce Innovation and Reform Strategy* (2013) identified five priority areas for change: i) align rural and remote workforce development with current health reform initiatives; ii) enhance growth of education, clinical training and career opportunities in rural areas; iii) support leadership development at all organizational levels; iv) plan for the optimal use of skills and adoption of workforce innovation and reform by developing approach in support of the rural health workforce; v) enhance industrial and legislative framework to facilitate workforce reform policy implementation in rural areas.

The issues and solutions regarding workforce retention are consistent across the globe. Broad-based integrated, collaboratively designed approaches that provide incentives that are responsive to the specific needs of rural workers and their communities tend to achieve the greatest successes. Consistent leadership, partnerships and relevant policy support are key to the development, implementation and sustainability of the reform process.

Transforming and Scaling Up Health Professional Education and Training (WHO, 2013)

In the context of health care, regulators are charged with ensuring that the public have access to competent health care providers. The regulation of health professions education must therefore ensure that physicians, nurses and midwives and other allied health providers receive quality education that prepares them to provide safe, competent and ethical care, are certified or licensed upon entry to professional practice and maintain competency through their active clinical careers.

Several key challenges affect the ability of countries to regulate the education of their health professionals. These include: i) outdated and irrelevant practice acts; ii) lack of clear core competencies guiding both education and practice; and, iii) lack of capacity to reliably measure

attainment and maintenance of competency. In addition, professional boards or councils frequently lack the resources or authority appropriate for their regulatory responsibility.

Transformative scaling up of health professionals' education and training is defined as the sustainable expansion and reform of health professionals' education and training to increase the quantity, quality and relevance of health professionals, and in so doing strengthen the country health systems and improve population health outcomes. As such, new policies are needed in five guideline domains: education and training institutions, accreditation and regulation, financing and sustainability, monitoring and evaluation and governance and planning.

The report recommends that:

- i) Professional training institutions should implement continuous development programs;
- ii) Government funding and accreditation bodies should support policies for mandatory faculty development programs;
- iii) Faculty expansion should include the recruitment of community-based clinicians;
- iv) training institutions should adapt curricula to meet evolving community health care needs;
- v) Training institutions should use simulation methods appropriate to the contexts in which they will be practicing;
- vi) Training institutions should consider direct entry of graduates from relevant programs into different or other levels of professional studies;
- vii) Training institutions should target admission policies to increase the socioeconomic, ethnic and geographical diversity of students;
- viii) Training institutions should streamline education pathways or ladder programs for the advancement of practicing health professionals;
- ix) Training institutions should implement inter-professional education at both undergraduate and graduate levels;
- x) Governments should introduced accreditation of health professionals' education where it doesn't exist, and strengthen it where it does exist.
- xi) Training institutions should implement continuous professional development and in-service training of health professionals relevant to the evolving health care needs of their communities.

In order for this plan to be implemented, political commitment and leadership will be required. In addition, formal accountability and collaboration is required between Ministries of Health, Education, Finance, Labour and the Public Service. A national plan, developed in consultation with stakeholders, informed by identify community needs and the absorptive capacity of the labour market and aligned with the national health plan, will be critical to its success.

International agencies such as the International Council of Nurses (ICN), International Confederation of Midwives (ICM), World Federation of Medical Education (WFME) and World Health Organization (WHO), have invested in the development of strategies and tools aimed at improving educational quality. Successful efforts will depend upon policies that actively build capacity to implement regulatory solutions that are based on emerging, international evidence-based guidance. The WHO 2013 report provides a framework to help guide that process.

CONCLUSIONS

A great deal of work – research, reports, plans and resolutions – has been undertaken over the past decade with respect to strengthening HRH and PHC in support of advancing UHC. The weight, scope and quality of what been produced, and the mounting level of political and administrative interest in the topic of HRH, suggest that there is reason for significant optimism with respect to maintaining the momentum on the issue and for identifying opportunities to effectively orchestrate comprehensive and collaborative change.

HRH issues are known, country experiences have been documented, ‘best practices’ and conditions for success have been assessed, and, the collaborative partnerships and future directions required have been broadly identified. The next step is to do it.

A number of major collaborative, technical and administrative actions - supported by strong, concurrent fiscal and political commitments - will be required to ensure the successful implementation and coordination of a sustainable HRH plan at country, regional and international levels. An HRH *change management strategy* will be required to provide coordination oversight and evaluation of the implementation process, to identify all relevant partner roles and accountabilities and to ensure that support is available, as required, to maintain program direction and momentum.

While many diverse partners and stakeholders are involved in the overall HRH reform process, the emphasis here is on two major principal players engaged in the process – government and PAHO/WHO. While countries are ultimately responsible to manage their own health systems and health workforces, many still lack the resources and capacities to do it effectively. Given the level of international interest and support for HRH that has emerged of late, PAHO/WHO has the opportunity to play an even greater role in assisting countries within the Region to better plan, guide, monitor, facilitate and coordinate their respective HRH planning processes.

Some critical steps in continuing to build the HRH reform process are set out below.

SUPPORTING HRH REFORM: Recommendations and Next Steps

GOVERNMENT

It is recommended that governments undertake to:

- i) Develop comprehensive, country HRH strategic plans that are consistent with and supportive of government health strategies and long-term business plans.
- ii) Identify government funding targets and benchmarks with respect to health as a percentage of GDP, health as a percentage of total government expenditure, and HRH costs as a percentage of total health expenditure, that are appropriate to support ongoing HRH reform and the implementation of UHC.
- iii) Enhance the stewardship and oversight function of the *Ministry of Health* to promote evidence-based policy development and decision making in support of the continued implementation of PHC under UHC.

- iv) Better integrate and coordinate the work of the Ministry of Health with Advanced Education, Immigration, Public Service, Community Services and Finance, to ensure ongoing consistent, relevant and viable policy development and fiscal support for HRH, PHC and UHC.
- v) Include fiscal plans and risk analyses with HRH strategies to keep them high on the government radar. Frame knowledge translation strategies in ways that acknowledge the critical role of HRH in the successful implementation of *all* health reform strategies.
- vi) Adopt a “health in all policy” approach at the government-wide level; and, a “HRH in all health policy” approach at the Ministry of Health level to enhance coordinated HRH planning and to ensure appropriate fiscal support and long-term sustainability of all health policies and programs.
- vii) Strengthen HRH information systems to include indicators of workforce stability, deployment and mobility, including linkages to health services utilization and health outcomes data.
- viii) Adopt the WHO *Code of Ethics* with respect to the utilization of international health care workers; and adopt the policy of *self-sufficiency* with regards to country health workforce development to reduce overall dependence on migrant workers over the longer term.
- ix) Develop health care delivery models and funding mechanisms that are based on established best practices, but are closely tailored, in collaboration with stakeholders, to local community settings, needs, capacities and priorities.
- x) Develop a blended approach to *health needs identification* that incorporates capacity-based, utilization-based and needs-based planning in order to be sensitive to ongoing health service demands and current resource constraints in the short-term, while merging with established population-based, epidemiological targets for the longer-term. (*Appendix A*)
- xi) Adopt a whole system approach to improving *productivity*, by developing worker capacity, ensuring optimal utilization and providing workplace support with the aim of enhancing overall workforce stability, efficiency and effectiveness in improving population health. (*Appendix B*)
- xii) Develop HRH planning mechanisms that include broad-based participation at the community level to encourage dialogue on local health issues in order to enhance the relevance and sustainability of HRH planning initiatives.
- xiii) Develop criteria for evidence-based decision making and needs-based planning.
- xiv) Develop the requisite policy and planning tools to oversee, support, manage and evaluate, the ongoing development of the HRH workforce, PHC and the implementation of UHC. (*Appendix C*)
- xv) Introduce *matrix* planning to maximize HRH planning unit access to ongoing inter-Divisional Ministry of Health staff support and information.

- xvi) Strengthen HRH *managerial skills and capacities* at national and district levels, to better support the health workforce, to improve recruitment and retention initiatives and improve overall stability.
- xvii) Support integrated and concurrent *HRH capacities and skills development* (Personnel Managers, HRH Planners and Health Care Providers) to improve overall health system management, governance and service provision with respect to achieving program efficiencies and implementing overall health reform. (Appendix D)
- xviii) Establish built-in *evaluation* mechanisms with respect to introducing *all* new health policies and programs, to improve monitoring capacity, contingency planning and overall health system accountability.
- xix) Adopt a *change management* approach that identifies all partner roles and accountabilities with respect to health policy development, implementation, monitoring and evaluation, at national and district levels.
- xx) Strengthen *community health service delivery* options by building stronger PHC teams that link with community networks, workers and services, including informal caregivers and volunteer services, and by strengthening and expanding nursing, midwives and community health worker roles, supported by innovative care models.
- xxi) Enhance coordination and alignment of *external development agency* funding initiatives with Ministry of Health policies, plans and program priorities to enhance their viability, make best use of limited resources and to strengthen long-term sustainability of both donor health initiatives and Ministry programs.
- xxii) In light of the broad policy support required by Ministries of Health in this regard, a wide range of *corporate capacities and planning competencies* need to be developed to advance the HRH reform agenda in support of PHC and UHC:
- *Advocacy* – to promote and support HRH at national and sub-regional levels.
 - *Integrated Change Management* – to identify partner roles, responsibilities and accountabilities in achieving collaborative goals.
 - *Fiscal Planning and Management* – to better align planning targets with fiscal capacity.
 - *Strategic Planning* – to better align HRH policies, plans and programs with health goals.
 - *Evaluation* - to regularly monitor and assess progress towards achieving HRH goals.
 - *Program Planning* – to develop HRH programs in support of HRH policies.
 - *Policy Development* – to develop HRH policies in support of HRH strategic plans.
 - *Inter-Sectoral Collaboration* – to achieve greater cost-effectiveness and political support through expanded and innovative partnerships.

- *Leadership* – to be proactive and to provide guidance with respect to marshalling appropriate resources and support towards achieving identified common goals.
- *Systems Thinking* – to consider the implications HRH policies, plans, programs and actions on the overall health sector over time.
- *Database Management and Sharing* – to utilize data to its full capacity to support joint HRH planning on an intra-regional basis.
- *Epidemiological Analysis* – to examine the health profile of the population to determine disease incidence both now and in the future.
- *Communications* – to ensure that partners and stakeholders are kept informed with respect HRH policies, plans and programs as well as emerging trends and issues.
- *Research* – to collect data and information to promote evidence-based decision-making.
- *Knowledge Transfer* - to promote evidence-based decision-making through the exchange of the best data and information available.

Education and Training

- xxiii) Mandate *social accountability* of health professional schools to ensure optimal alignment of the quantity and quality of graduates with the needs of the health care system, and to enhance their relevance and support at the community level.
- xxiv) Use targeted admission policies to enroll students with a rural background in education programs for various health disciplines, in order to increase the likelihood of graduates choosing to practice in rural areas.
- xxv) Design continuing education and professional development programs that meet the needs of rural health workers that are accessible from where they live and work, so as to support their retention.
- xxvi) Provide scholarships, bursaries or other education subsidies with enforceable agreements of return in service in rural or remote areas to increase recruitment of health workers in these areas.
- xxvii) Mandate that professional training institutions implement continuous development programs with respect to curricula and faculty development.
- xxviii) Strengthen health professional education accreditation requirements, standards and processes.

Legislation and Regulation

- xxix) Develop standardized professional legislation to maximize public protection while minimizing any barriers to the innovative deployment of HRH in the PHC setting.
- xxx) Consider the development of *omnibus* professional legislation to simplify the regulatory process and provide a mechanism to cover emerging and new health

disciplines, and to increase options for public protection and to ensure quality of care when developing community-based, informal caregiver scenarios.

- xxxi) Introduce and regulate enhanced scopes of practice in rural and remotes areas to increase the potential for job satisfaction thereby assisting recruitment and retention.
- xxxii) Under the auspices of UHC, establish clearer practice guidelines, and more appropriate funding models and PHC delivery mechanisms to reduce the competition between the public and private sectors and strengthen the overall health system.
- xxxiii) Where appropriate, bring professional acts up to contemporary regulatory standards to account for the issue of continuing professional development.
- xxxiv) Ensure government policymakers, regulators and international development partners and their donors work together to build strong systems of accreditation, licensure/registration and continuing professional development, employing international competencies and standards as far as possible.

Personal and Professional Support

- xxxv) Provide a good safe working environment, with appropriate equipment and supplies, supportive supervision and mentoring to make positions professionally attractive.
- xxxvi) Identify and implement appropriate outreach activities to facilitate cooperation between health workers in better served areas and those in underserved areas, using *telehealth* where available to provide more immediate and direct support and oversight of health care delivery. Utilizing discarded or last –generation communication technology, with expanded band-width capacity for rural areas, would greatly enhance this capacity.
- xxxvii) Support the development of professional networks, rural health professional associations, etc. to improve worker morale and status and reduce feelings of professional isolation.

Research

- xxxviii) There is a plethora of HRH research globally to inform Regional policy and program directions with regards to enhancing HRH capacity and supporting PHC and UHC implementation. Undertake appropriate, topic-based *research synthesis* to assist countries greatly by identifying the critical conditions for success - within various politico-economic country scenarios - to enable countries to select program options and approaches that are most applicable to their local settings.
- xxxix) Develop *knowledge transfer and exchange* protocols to determine best practices and conditions for success to facilitate the inter-country exchange of data and research, and to enhance its relevance with respect to government policy and program development.
- xl) Standardize HRH *program evaluation* mechanisms to further facilitate information exchange and the identification of best practices, and ensure that they are included up-front as a component of all new programs to ensure ongoing accountability.

PAHO/WHO

The basic goal of an *HRH Observatory* is to support actions that address HRH challenges through promoting, developing and sustaining a firm knowledge base that is founded on solid and updated HRH information, reliable analysis and effective use at national, sub-regional and regional levels. Given the recognized need to improve governance at the planning, management and service delivery levels, it would appear that there may be opportunities to expand the role of the Observatory to provide broader technical assistance and support in a number of HRH policy, planning and management areas that would benefit from joint development and coordination at the regional level.

While investing in improving the skills of planners, managers and service providers will be a requisite part of a long-term Regional strategy, other kinds of support may be required in the short and medium terms to help strengthen each country's planning framework. Economies of scale can be achieved in developing consistent approaches to a host of HRH planning issues (listed below). A coordinated, regional or regional approach regarding these issues would contribute to workforce stability by creating a more level HRH playing field. Regional consensus on these issues and priorities may also attract donor support insofar as a consolidated and consensual inter-country approach offers the promise of greater program success and long-term program sustainability.

PAHO could encourage the expansion and strengthening of the Observatory function in close collaboration with country Ministries of Health. PAHO would have the opportunity to provide leadership in strengthening country governance mechanisms would provide the support necessary to facilitate the successful implementation of UHC.

It is recommended that PAHO/WHO:

- i) Provide leadership in guiding and coordinating the post-2015 HRH agenda.
- ii) Revise the *Regional HRH 20 Goals*, and assist as appropriate, in revising the HRH component of the *Millennium Development Goals*, to reflect new targets with respect to defining more detailed HRH targets (numbers, mix, migration, mobility, stability, deployment, training and funding) and UHC goals (identify funding benchmarks, program scope, population reached, etc.).
- iii) Strengthen the oversight role of Regional, sub-regional and country-level *Observatories* to provide technical support, as appropriate, to develop and standardize HRH planning approaches to enhance Regional HRH planning capacity in the following areas as priorities, resources and time constraints allow:
 - Provide a clearing house for relevant HRH information
 - Knowledge transfer and exchange
 - Recruitment and retention strategies and incentives
 - Public-private partnership roles and options
 - Regional migration strategies
 - Forecasting techniques
 - Standardized mid-level health worker development
 - Develop a common framework for HRH planning
 - Quality assurance approaches and guidelines

- Approaches to health system needs assessment
- Technology selection, application assessment
- Governance Mechanisms (incl. professional regulation and accreditation)
- Information system development
- Coordinated needs identification and training development
- identification and planning of collaborative *centers of excellence*
- Program evaluation standards, guidelines and application
- Communication strategies
- Research synthesis on key HRH priorities
- Pilot projects re HRH incentives and retention schemes,
- Donor activity coordination
- Risk assessments
- PHC model selection guidelines
- Facilitation of coordinated Regional HRH planning

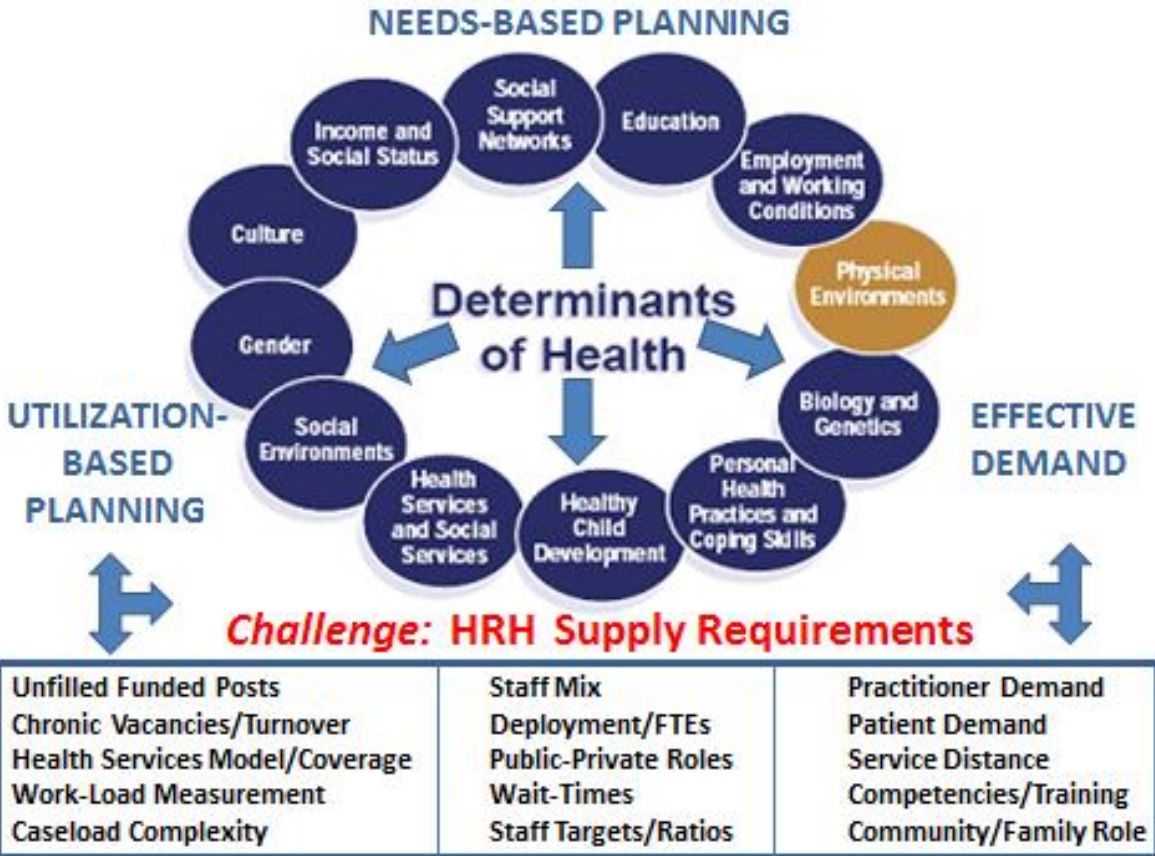
NEXT STEPS

A recommended next step would be for PAHO to take leadership in convening a Regional meeting to begin the process of identifying, planning, developing and coordinating a new, collaborative, post-2015 HRH strategy for the Region of the Americas.

The approach would be evidence-based, and, building on the Regional work completed thus far, would have the aim of enhancing the overall HRH capacity in support of the advancement of PHC and UHC. Building on ongoing international initiatives and in support of current PAHO program directives the process would begin by identifying appropriate planning partners, priorities and timelines.

The summary directions and recommendations contained in this report are intended to stimulate that dialogue and provide a strategic place to begin.

REFERENCES





Health Workforce Productivity



Education & Training

Workforce Culture, Communications & Expectations

Supply & Mix

Models of Care

Matching Competencies to Requirements

Provider Roles & Deployment

Mix, Numbers & Distribution

Occupational Health & Safety

Personnel Management Practices

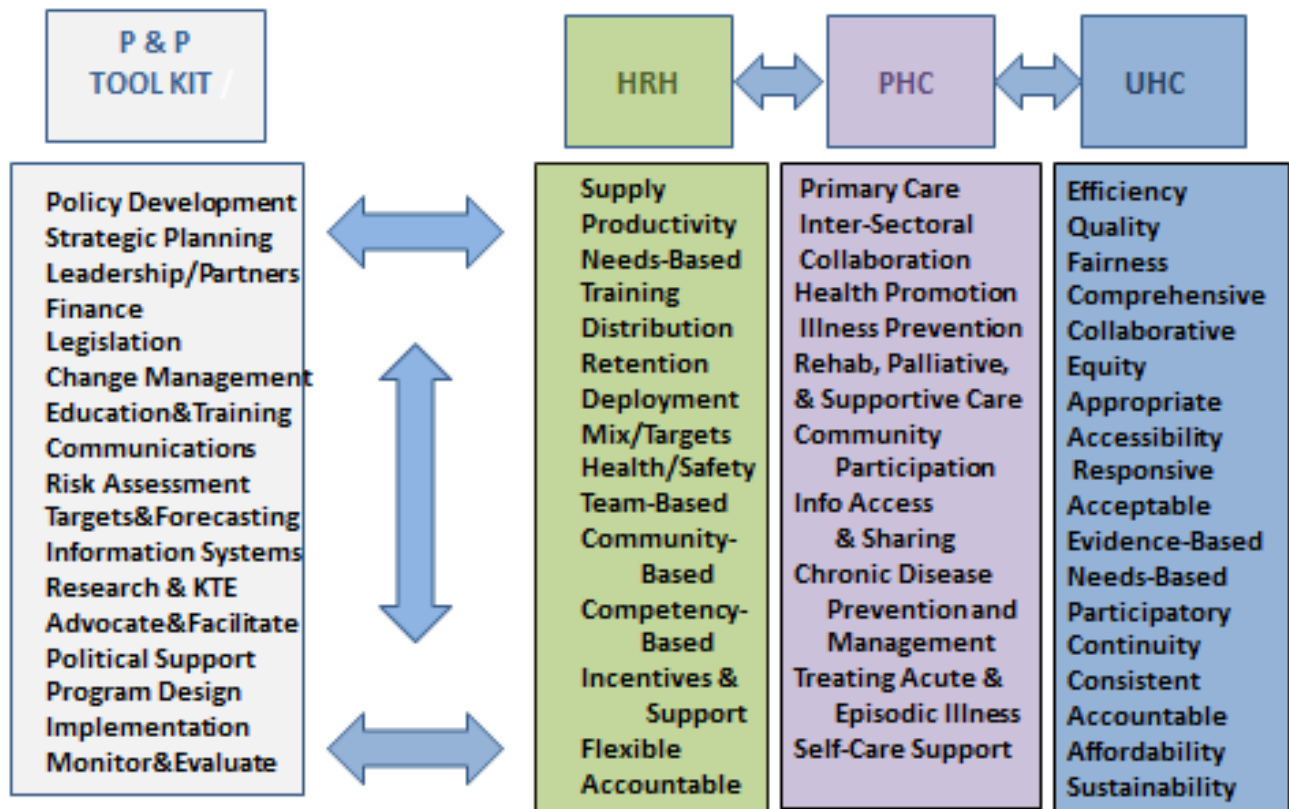
Innovation & Support

Stability of Workforce

Efficiency in health services delivery

Effectiveness of Patient Care, Health Outcomes & Population Health

HEALTH SYSTEM REFORM: Role of HRH Policy & Planning



HRH Capacity & Skills Development

